MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Wol+Med, Edward Wolski, M.D. 2436 I-35 East, South, Ste. 336 Denton, TX 76205	MDR Tracking No.: M4-04-2467-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address ARCMI P.O. Box 115114 Carrollton, TX 75011	Date of Injury: Employer's Name: Wal Mart Stores Insurance Carrier's No.: C2265947

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/23/02	06/05/03	99213 (6 dates of service)	$288.00	$288.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary states in part, "For dates of service 10/23/2, 12/9/2 and 5/2/3 the carrier denied the charges using PEC-E. The injured employee has had a Contested Case Hearing where her cervical and lumbar injury was deemed a result of the___ injury. We have included this in our documentation for review… For dates of service 2/5/3, 2/20/3, 6/5/3, the carrier failed to respond to our initial billing. We feel they have failed to comply with Rule 133.304…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary states in part, "…on behalf of the above referenced insurance carrier, in response to the Requestor's dispute regarding fee reimbursement for date of service of October 23, 2002 through June 5, 2003. As a result of this review of the additional documentation submitted no further payment has been recommended…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Respondent has denied the disputed dates of service for "E" and "R". The EOBs submitted by the insurance carrier list a diagnosis code of 722.10; however, review of the submitted HCFA-1500's doesn't include that diagnosis code and MDR is unclear why the insurance carrier has listed this particular diagnosis code as the HCFA-1500s list Dx codes 847.2, 724.2, and 847.0. The injured worker prevailed at the Contested Case Hearing of August 14, 2003; therefore, the disputed dates of service will be review according to the 1996 Medical Fee Guideline.

- CPT Code 99213 for dates of service 10/23/02,12/09/02, 02/05/03, 02/20/03, 05/02/03, and 06/05/03. Per the 1996 Medical Fee Guideline, Evaluation & Management Ground Rule (IV)(C)(2) clinical notes support services were rendered as billed. Reimbursement in the amount of $288.00 is recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $288.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	02/17/05

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____